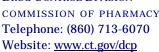
PCY-01, Rev 9/09

## STATE OF CONNECTICUT

## DEPARTMENT OF CONSUMER PROTECTION

DRUG CONTROL DIVISION COMMISSION OF PHARMACY Telephone: (860) 713-6070





For Official Use Only	
	For Official Use Only

## **APPLICATION FOR PHARMACY LICENSE** \*\* CONNECTICUT/IN-STATE PHARMACIES ONLY \*\*

## **INSTRUCTIONS:**

All spaces must be completed - please print in ink or type. This application must be accompanied by a check or money order for the appropriate fee as listed below, made payable to: "Traceuren State of Connecticut". Application for the appropriate fee as listed below, made payable to: "Traceuren State of Connecticut".

non-re 1.	<b>fundable.</b> This of the time who manager, chang	application n en it is desire ge of name an ularly schedu	listed below, made planst be filed at least filed to have such licens d/or change of officers, led Commission of Ph	ifteen se go i /direc	n (15) d into ef ctors.	days in adv fect if appl	/ance licati	e: on is for a change o	f ownership	o, change of	
→ Retu	ırn your complete			seo So	omvico	ne 165 Can	sital	Avanua Hartford	CT ORIOR		
	Applying For:  New Pharmacy License (\$750.  Change of Ownership (\$90.00 feed)  Change of Manager (\$90.00 feed)				0 fee) Change of Name (\$90.00 fee)						
Regular practice In mak type of Pharm	tions, Section 20- e in which your pl ing your selection business or profe Com	576-54, be clanarmacy is in syou should ossional practimunity	New Pharmacy Lice assified in one or more volved. You may oper consider that the class ce in which your pharm Infusion Therapy	e of th ate in s or cla macy	ne clas n one o asses y is inve	ses below, or more clas you choose olved.	base sses v shou	ed upon the type of p with no increase in t ald reflect, in a subs	harmacy/b he license f tantial mar	usiness ee you pay.	
Name o	of Pharmacy										
Street A	Address				City or Town				State	Zip Code	
Telephone Number (w/ Area Code) FEIN Number			FEIN Number				If (	If Change, Current Pharmacy License Number			
New Pharmacist Manager (Name & Address)							Ne	New Pharmacist Manager (License Number)			
Owner	ship Informatio	n:									
	Legal Standing:  Individua  f Owner	al 🗌 Pa	rtnership	rporat	tion			Liability Company s (Street, City, State	& Zip)		
	cant is NOT the so ceutical affairs of s		the owner or owners app	pointe	ed appl	licant as ma	ınage	er of the pharmacy wi	th complete	power over the	
	oration or Unin							1			
Business Address of above corporation or association (Street, City, St				ty, State & Zip)  Date and Place of Legal Organization							
List Na	ames of Officers	, Directors:									
Name (I	Name (First,Last) Ad			Addr	Address (Street, City, State & Zip)						
Name (I	e (First,Last) Ad				Address (Street, City, State & Zip)						
Name (I	ne (First,Last)				Address (Street, City, State & Zip)						

If this is an application for a new pharmacy, a change of ownership, may of directors ever been convicted of a felony crime? $\square$ YES $\square$ NO conviction(s), the court(s) where the case(s) were decided and a descrip						
If Individual or Partnership:						
List names of all partners [include applicant if one of the partners]. If	more than three partners, attach rider setting out all names.					
Name (First,Last)	Address (Street, City, State & Zip)					
ne (First,Last)  Address (Street, City, State & Zip)						
Name (First,Last)	Address (Street, City, State & Zip)					
If this application involves a change in Pharmacy Name, Mana information requested in the appropriate box (es) below:	ger, Location or Ownership - please provide the					
PREVIOUS: Name of Pharmacy & Pharmacy License Number	PREVIOUS: Name of Pharmacist Manager and License Number					
PREVIOUS: Location (Street, City, State & Zip)	PREVIOUS: Name of Owner(s)					
Name and license number of each pharmacist employed at	his location:					
Name (First,Last)	License Number					
Name (First,Last)	License Number					
Name (First,Last)	License Number					
Store Hours of Operation:						
Daily - Weekdays a.m p.m	. <b>Saturday &amp; Sunday</b> a.m p.m.					
<b>Prescription Department Opening and Closing Hours</b> (if different	nt and pre-approved by Pharmacy Commission)					
<b>Daily - Weekdays</b> a.m p.m.  Please list additional information concerning hours of operation below:						
I hereby appoint	to have complete control and management					
(Name of Pharmacist Manag over this pharmacy's premise.	er/Applicant)					
Signature - Owner or Authorized Officer State the approximate time the pharmacy will be ready for inspection						
Applicant Signature (Pharmacist Manager)	AFFIX PRESCRIPTION LABEL OR REASONABLE FACSIMILE OF LABEL HERE					
Signature Owners Signature Owners(s)  * Note: If the owner is a partnership, all partners must sign this application. If the owner is a corporation, this application must be signed by a duly authorized official of said corporation						
TO BE FILLED BY THE TOWN, CITY, OR BOROUGH CLE						
This is to certify that I am acquainted with the zoning ordinances a this Pharmacy is not prohibited by either the ordinances or by-law	nd by-laws of the town/city listed below and that the location of					
Name of Town/City/Borough	Signature - Zoning Authority					
Town/City/Borough Clerk	 Date					